STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
Financial Affairs / Analytical Unit 0576
500 James Robertson Parkway, 4th Fl.
Nashville, TN 37243
615-741-1633

December 14, 2007

PLEASE READ - IMPORTANT INFORMATION

RENEWAL FOR THE PRIVILEGE OF PAYING WORKERS' COMPENSATION WITHOUT INSURANCE

TO: **SELF-INSURED ADDRESSED**

FROM: **Bob Ribe, Chief Analyst**

January 31, 2008 is the due date for filing with this Department the renewal application, **March 1, 2008** is the due date of payroll report for calendar year 2007, and **April 15, 2008** is the due date of experience modification factor ("EMOD") for calendar year 2008, in order to continue the privilege of self-insuring the payment of workers' compensation claims that arise in this State. If payroll report and EMOD are not received by the due date the Division will determine your premium tax based upon a rate calculated by the Division. Employers must remit payment within 15 days of the receipt of their invoices.

Tenn. Code Ann. § 50-6-405(b)(2) requires all self-insurers of workers' compensation to file with this Department evidence of their financial ability to pay all claims that may arise against the employer in the form of an annual certified financial statement, including a statement of assets and liabilities and a statement of profits and losses to be filed no later than six (6) month after the company's immediately preceding fiscal year. The financial statements are to include a detailed accounting of reserves outstanding losses incurred in connection with workers' compensation self-insurance. Losses and adequacy of reserves must be certified biannually by a qualified actuary. **Please be advised that Tenn. Code Ann. § 50-6-405(b)(4) authorizes the Department to take action against a company's certificate of authority to self insure for failure to provide the requested documents.**

You will find enclosed one (1) copy of the renewal application and one (1) copy of the payroll report form. You are required to complete these forms and return them to this Department by **January 31, 2008 and March 1, 2008** respectively. Please retain a copy of each for your files.

Any changes made to your program such as addition or deletion of locations, changes in ownership or subsidiaries, name changes, contact person or claims handler changes, or address changes, should be addressed in the form of a cover letter attached to the renewal information being submitted.

Please send as part of the renewal process, detailed paid loss information valued as of December 31, 2007, for the years 2005, 2006, and 2007. Also, please provide open claims information. **(Please see attached list of special notice.)**

ALL Self-Insurers are required to furnish this Department with a **Tennessee experience modification factor.** Application for this should be filed promptly with the National Council on Compensation Insurance (NCCI) as the modifier is required for calculation of Self-Insurance Taxes. The 2008 factor will be based on losses from 2004, 2005, and 2006. **PLEASE APPLY FOR YOUR EXPERIENCE FACTOR UPON RECEIPT OF THIS RENEWAL NOTICE. PLEASE INSURE THE EXPERIENCE MODIFICATION FACTOR IS EFFECTIVE JANUARY 1, 2008, WITH LOSS INFORMATION ON A CALENDAR YEAR BASIS. INTERSTATE EXPERIENCE MODIFICATION FACTORS, OR FACTORS CALCULATED BY ANYONE OTHER THAN NCCI WITHOUT THE WRITTEN APPROVAL OF THE COMMISSIONER ARE NOT ACCEPTABLE TO THE STATE OF TENNESSEE. INFORMATION SUBMITTED TO NCCI TO PROMULGATE YOUR EXPERIENCE MODIFICATION, SHOULD MATCH EXACTLY WITH PREVIOUS PAYROLL INFORMATION SUBMITTED TO THE STATE OF TENNESSEE FOR CALCULATION OF TAXES.**

ALL EXPERIENCE RATING MODIFICATIONS ARE SCHEDULED FOR CALCULATION AND ISSUANCE AT LEAST THIRTY (30) DAYS PRIOR TO THEIR EFFECTIVE DATE.

National Council on Compensation Insurance
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487
Phone: 561-893-1000 or 1800-622-4123
Fax: 561-893-1191

Please see Self-Insured Workers' Compensation Single Employer Rule 0780-1-83 & Rule 0870-1-81 for recent proposed changes to the self-insurance program. If you are unable to read or print from the links below, please contact us at Jarasbot.kirsch@state.tn.us, http://www.state.tn.us/sos/rules/0780/0780-01/0780-01-83.pdf http://www.state.tn.us/sos/rules/0780/0780-01/0780-01-81.pdf

Please remit ALL requested materials to:

Jara Kirsch, Insurance Analyst
Department of Commerce and Insurance
Financial Affairs / Analytical Unit 0576
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243

JK
Enclosures

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
Financial Affairs Section / Analytical Unit 0576
500 James Robertson Parkway, 4th Floor
Nashville, Tennessee 37243
(615) 741-1633

Notice Information Needed For 2008 Renewals

To : All Self-Insurance Companies

From : Bob Ribe, Chief Analyst

Re : Workers' Compensation Self-Insurance Program

Date : December 14, 2007

As part of the Department's annual review of Self-Insurance Companies in Tennessee, we require the following information:

PLEASE PROVIDE	DESCRIPTION
☐ 1	**Application – Completed in its entirety, signed and Notarized, Deadline January 31, 2008.**
☐ 2	**Payroll Report** – Actual payroll for 2007 calendar year, signed and notarized (form must bear original signatures), **Deadline March 1, 2008.**
☐ 3	**Intrastate Experience Modification** – Effective Date January 1, 2008, **Deadline April 15, 2008.**
☐ 4	**Independently Audited Financial Statement** – Must be filed no later than the last day of the sixth (6th) month after end of its immediately preceding fiscal year – failure to comply with this requirement could result in a civil penalty of $100 per day for each day the filing requirement is not met.
☐ 5	**Reserve Report Accompanied by Actuarial Opinion** - Must be filed no later than the last day of the sixth (6th) after the end of its immediately preceding fiscal year on a biennial basis.
☐ 6	**Loss Run Reports for 2005, 2006, 2007 –** with summary page for each year.
☐ 7	**Open Claims –** Summary all reserves outstanding since inception of self-insurance.
☐ 8	**List of Open and Paid Claims** which have hit and exceeded the self-insured retention (SIR) for 2005, 2006, and 2007.
☐ 9	**Excess Policy accompanied by Actuarial Certification –** this should include both **Specific and Aggregate. If Aggregate insurance is not included, a statement from the actuary waiving this requirement must be filed.**
☐ 10	Third Party Administrator ("TPA") that is licensed in accordance with Rule 0780-1-81.
☐ 11	Name, Address and E-mail of contact person from Tennessee
☐ 12	Evidence of current amount of Securities; copies of bond, certificate of deposit, UST Notes, UST Bonds, or Letter of Credits.
☐ 13	Parent Guarantee if applicant is a subsidiary
☐ 14	If item #2 and #3 are not received by the due dates, the Division will determine your premium tax based upon a rate calculated by the Division. The employer must remit payment within 15 days of the receipt of their invoices.

STATE OF TENNESSEE
RENEWAL APPLICATION FOR WORKERS' COMPENSATION SELF-INSURANCE

EACH BLANK MUST BE ANSWERED IN FULL

THE DEPARTMENT OF COMMERCE AND INSURANCE
Financial Affairs / Analytical Unit 0576
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243

Date Completed _____
DUE on or before January 31, 2008

The undersigned employer (applicant) submits the following statements and reports of qualifications to carry its own risk under provisions of the Workers' Compensation Act of Tennessee.

1. Name of applicant _____ FEIN# _____

2. Address _____
Street City County

_____
State Zip Code+ Phone Number

3. The applicant is _____
(State whether a corporation, public authority, or other)

4. List below the name and addresses of officers and directors of the corporation.
Title (as "Officer", "President", Director") Name Address
a. _____
b. _____
c. _____
d. _____

5. Date of commencement of self-insurance in Tennessee _____

6. Chartered under the laws of the state of _____ on _____
Date

7. If a foreign corporation, give date of registration in the office of the Tennessee Secretary of State _____
Date

8. Has there been any change in corporate structure within the last two years? _____
If yes, explain. _____

9. Has applicant any affiliates, subsidiaries, or divisions operating in Tennessee? _____ If so, give following information :
Yes or No

	State whether affiliate, division or Subsidiary	**Name and office address***	**Character and location of business**
a.			
b.			
c.			
d.			

***Attach a schedule if more space is required.**

10. Is applicant a subsidiary? _____ If so, give name and address of Parent Company, and list all subsidiaries.
Yes or No

(1) Parent Company is _____
Name Street City State Zip

(2) Its subsidiaries operating in the State of Tennessee are:

	Name*	**Office Address**	**City, State, Zip Code**
a.			
b.			
c.			
d.			

***Attach a schedule if more space is required.**

11. Description of employment..... For year ending... _____

Location in Tennessee (City)	**Kind of Employment**	**Average number of employees in TN**	**Actual Payroll for all employees in Tennessee**
			$
			$
			$
			$
	TOTALS		$

12. Name and address of Person/Company administering claims in Tennessee: _____
_____

13. Past three-year Accident Experience

		Year		Year		Year	
a.	Number of deaths	#		#		#	
b.	Number of dismemberments	#		#		#	
c.	Number of temporary disabilities exceeding 7 days duration	#		#		#	
d.	Number of accidents of all kinds	#		#		#	

14. In consideration of the approval of this application, the applicant hereby expressly agrees as follows:
    a. That this privilege may be revoked by the Commissioner of Commerce and Insurance, as provided in Tenn. Code Ann. § 50-6-405.
    b. That the applicant, who is carrying catastrophe or excess coverage insurance, shall file a photocopy of the policy with the Department of Commerce and Insurance.
    c. That the applicant shall file with the Commissioner an acceptable security amounting to at least five hundred thousand dollars ($500,000).
    d. That the employer will not solicit, receive or collect any money from employees or make any deduction from their wages for the purpose of discharging any part of the employer's liability under the Workers' Compensation Act and that the employer will not permit any person with the employer's knowledge to sell or try to sell medical or hospital tickets to the company's employees for medical, surgical or hospital treatment required by law to be furnished to injured employees.
    e. When the applicant is a subsidiary company or a partnership, the Commissioner requires that the parent company, or any other company or persons holding stock in the applicant company, or a partner in the applicant partnership, shall give a satisfactory guarantee that the applicant will fully and promptly pay all sums which are or may become payable under the provisions of the Tennessee Workers' Compensation Law and under the terms of the agreement contained in this application.

15. Rating Agency: Indicate whether your company or parent company is rated by the following rating agencies:

_____ Yes _____ No, and if YES, indicate present rating:

Standard & Poors Corporation _____

Moody's Investors Service, Inc. _____

Dun & Bradstreet _____

Other: _____

16. Loss Runs for the three latest calendar years valued as of December 31, 2007. (Attach copy of detailed loss runs.)

YEAR	INCURRED	PAID INDEMNITY	PAID MEDICAL	RESERVED	EXCESS RECOVERABLE
2005	$	$	$	$	$
2006	$	$	$	$	$
2007	$	$	$	$	$
TOTALS	$	$	$	$	$

Total reserve amount for all **open** claims **since inception** of self-insurance $ _____

Total amount of excess recoverable on all **open** claims $ _____

Signed _____ Self-Insured Employer

By _____

_____

(Official Position)

AFFIDAVIT

(The person subscribing the affidavit below should be the employer himself; or if the employer is a partnership, one of the partners; or if the employer is a corporation, its President, Vice-President, Secretary or Treasurer.)

STATE of - _____

_____ , County

_____ first being sworn on oath, deposes and says that he/she is the person who signed the foregoing application for the employer therein named, and that he/she is acquainted with the affairs of said applicant employer, to which the representations and statements set forth in the foregoing application relate: that he/she has read said application, knows the contents thereof and that said representations and statements therein contained are true to the best of his/her knowledge, information and belief.

_____ _____

(Affiant's Signature) (Official Position)

Subscribed and sworn to before me at _____ ,this _____ day of _____ A.D., _____

_____

(Notary Public)

STATE OF TENNESSEE
THE DEPARTMENT OF COMMERCE AND INSURANCE
4TH FLOOR, SELF-INSURANCE SECTION
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-1132

SELF-INSURERS PAYROLL REPORT

ITEM 1. TO THE COMMISSIONER OF THE DEPARTMENT OF COMMERCE AND INSURANCE:_____ 20_____.

The undersigned, an employer operating under the provisions of the Tennessee Worker's Compensation Act, as Self-Insurer, submits the following information for the purpose of enabling the Insurance Commissioner to determine the amount of tax due the State of Tennessee under provision of Section 50-6-405, Tennessee Code Annotated.

ITEM 2. Name of Employer .....

Address .....

ITEM 3. Figures contained in this report are for the purpose of adjusting the tax assessment made for the period of January 1, 20 ....., to December 31, 20....., and for making the assessment for the period of January 1, 20....., to December 31, 20_____.

ITEM 4.

CODE	CLASSIFICATION OF OPERATIONS USE TYPEWRITER EXCEPT FOR SIGNATURES.	AVERAGE NUMBER OF EMPLOYEES IN TENNESSEE FOR YEAR ENDING DEC. 31, 20___	ACTUAL/ESTIMATED PAYROLL OF ALL EMPLOYEES IN TENNESSEE FOR PERIOD OF _____ 20 __ TO_____ 20 __
	TOTAL		

NOTE IMPORTANT

1. CLERICAL OFFICE EMPLOYEES. — This classification shall include those employees with office duties only and having no other duty of any other nature in or about the employer's premises.
2. Unless the payroll below is subdivided into proper classifications, the highest rate will be used in calculating the premium.
3. If employer has multiple locations, please consolidate classifications.

RETURN TOP COPY TO THIS OFFICE — RETAIN YELLOW FOR YOUR FILES

ITEM 5. The foregoing enumeration and description of employees includes all persons employed in the services of this employer in Tennessee in connection with the business operations above described to whom remuneration of any nature in consideration of service is paid, in whole or in part by bonuses, commissions, vacation pay, holidays or sickness periods, or on basis of piecework, or by store certificates, merchandise credits, or any substitute for money. Such form of payment shall be considered as wages to be included in the actual remuneration earned, *and the total remuneration earned by each employee shall be reported excluding only the part of overtime as set forth in the basis of premium.* This remuneration shall also include the President and Vice-President, Secretary or Treasurer of this employer in every instance where the Executive Officer actually performs such duties as are ordinarily undertaken by a Superintendent, Foreman, or worker, or whose duties include direct charge of the actual performance of any obligations of the risk. The entire payroll of such an Executive Officer shall be assigned without division to the highest rated classification which applies to any such duties undertaken by such Executive Officer for any part of his time. The Department of Insurance reserves the right to examine the books of this Employer at any time during the current or following year and any extension thereof so far as they relate to the remuneration earned by any employee of this employer.

.....
Name of Company.

I, ... (Title), of the above named company do hereby solemnly swear that the items of the foregoing account are correct and that they constitute the total amount of remuneration received by all employees in the State of Tennessee for the period stated therein to the best of my knowledge and belief.

.....
Official and Title.

Subscribed and sworn to before me this ..... day of ....., 20 ..... .

My Commission Expires .....

.....
Notary Public.

INDEMNITY AGREEMENT

KNOW ALL MEN BY THESE PRESENT, that we _____,

a corporation, organized and existing under and by virtue of the laws of the State of _____, for and in consideration of the State of Tennessee authorizing _____, a corporation, to operate as a self-insurer under the provisions of the Workers' Compensation Law of the State of Tennessee do hereby guarantee the payment by said _____ of any and all valid claims for compensation and other benefits made against it under the said Workers' Compensation Law for injury or death to any of its employees or former employees and in the event that said _____ shall not pay or cause to be paid directly to claimants the benefits due or that may become due under said Law, then the undersigned _____, covenants and agrees that it will pay to all such claimants the benefits due, including a reasonable attorney fee incurred by said claimants in any action brought on this agreement, with the expressed knowledge and understanding that the execution and acceptance of this agreement is for the benefit of unknown and unnamed employees and former employees of said _____, and that said _____ does hereby recognize this agreement as a direct financial guarantee to said employees or former employees.

PROVIDED HOWEVER, that _____, shall have a right to cancel and terminate this agreement at any time upon giving the State of Tennessee at least sixty (60) days written notice of its desire to do so; provided further, that such cancellation shall not affect its liability as to any benefits payable for injuries occurring prior to the date of cancellation specified in such notice.

This agreement shall be effective as of _____, 20____.

Signed, sealed and delivered this _____day of _____, 20 ____.

_____

By:_____

_____

(Official Position)

ATTEST:

_____

Secretary

CORPORATE SEAL